MERCY HOSPITAL
& HEALTH SERVICES

October 16, 1997

David Werdegar, M.D., M.P.H., Director
Office of Statewide Health Planning and Development
Health Policy and Planning Division
1600 - 9th Street, Room 350
Sacramento, CA 95814

Dear Dr. Werdegar:

Thank you for the opportunity to comment on the California Hospitals Outcomes Project. Mercy Hospital and Health Services (MHHS) welcomes the opportunity to discuss the quality of our care and services.

While we support the concept and use of valid and reliable data comparison, we have discovered that reports such as the RAMO analysis do not provide the true picture of clinical care within a facility. This is of special concern when reports such as these are disseminated to the general public with the expectation that this information can be utilized as an indicator of quality.

In reviewing our hospital specific data for acute myocardial infarction, we note that we met the parameters of Model A. However, in Model B, when additional demographic and clinical indicators were evaluated, we received a "significantly worse than expected" rating. Through an intensive assessment of what is now four to six year-old data, we discovered many issues that have no bearing on the quality of clinical care that a patient actually receives. Following is a summary of our findings.

Technical/Coding Issues

- 96.2% of the patients in Model B were coded as urgent, as compared to 60.4% of the patients in the statewide statistics. We believe this factor had a strong influence on the risk adjustment, and is thus borne out by the difference in the ratings for the two models. According to the study, urgent was given the same risk adjusted rating as elective, therefore, miscoding related to the type of admission would have significantly affected the overall risk adjustment for this patient population.

- According to the study, MHHS had 42 observed deaths out of 229 patients.

- Of these 42 deaths, *seven* were not reviewed due to insufficient information from the report, however, we know they did not expire as patients of MHHS.

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- *Six* patients had been miscoded and should not have been included in the study due to an origin of Skilled Nursing Facility (3) or other acute care hospitals(3).

- *One* patient had a primary diagnosis other than AMI.

- *One* patient was miscoded, and was not actually an AMI.

- *One* patient had actually expired at home, was bathed and dressed in cultural clothing prior to the EMS call being placed.

After an extensive review of technical and coding issues we have concluded that, had the coding more accurately reflected the clinical condition of the patient, MHHS would have met or exceeded the parameters established for rating of AMI patient care.

Clinical Issues

- Of the twenty-six patients that expired during the sample size, 53.5% had ***Do Not Resuscitate*** or ***Limited Resuscitation orders***. MHHS is a strong advocate for patient self-determination and we actively provide patients and families with information related to critical decisions. The majority of patients in this study had lengths of stay less than one day and were brought to the hospital in a critical or a terminal state. We do feel that we have an obligation to care for patients' spiritual well-being with the same enthusiasm as we care for their physical well-being. Therefore, we believe that vital information such as code status should be an appropriate part of any quality study related to mortality.

MHHS had significant variation in the demographic and clinical characteristics of its patient population as compared to the statewide average. Those differences are as follows:

	MHHS	***State***
Age	76	67.3
Female	65.4%	36.9%
White	92%	78.3%
Renal Failure, Acute	10%	3.7%
Diabetes, Complicated	24.1%	18.7%
Pulmonary Edema	20.7%	8.1%
Inferior MI	27.6%	19.8%

- MHHS patient population was 8.7 years or 13% older than the statewide average. In addition, MHHS had a predominately female population. Recent studies released by the American Heart Association report that while more men have heart attacks each year, women have lower changes of surviving them. Their findings showed that 44% of women who have heart attacks will die within one year compared to 27% of men.

While we at MHHS understand and support the need for comparative clinical outcomes data, we have concluded that reports generated from financially driven reports such as those used in this study, call in to question the validity of any such data. Our analysis demonstrated that the coding practices of non-clinically based individuals had a strong influence on our reported clinical outcomes. In addition, it is apparent that as a facility, we serve a population that recent research has shown to be "at risk" for increased mortality. We strongly respect life and provide patients with an opportunity to participate in decisions regarding a quality existence. We are leaders in our community in issues related to patient self-determination and end of life decisions. We do not feel that we should receive adverse public scrutiny for our beliefs, nor do we feel a financially-driven model accurately reflects our philosophy.

It is with a full understanding of the public's need for information that we express our intent to support and participate in studies such as this one in the future. Again, thank you for the opportunity to present this response.

Sincerely,

Kelly C. Morgan
President and Chief Executive Officer

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